IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

LESLIE M. CLEMENT - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-5747
FAX: (208) 364-1811

November 8, 2007

Cari Riley, Administrator
Emerson House at River Pointe, LLC
8250 West Marigold
Garden City, ID 83714

License #: RC-725

Dear Ms. Riley:

On September 24, 2007, a complaint investigation survey was conducted at Emerson House at River Pointe, LLC. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

- Core issues, which are described on the Statement of Deficiencies, and for which you have submitted a Plan of Correction.

- Non-core issues, which are described on the Punch List, and for which you have submitted evidence of resolution.

This office is accepting your submitted plan of correction and evidence of resolution.

Should you have questions, please contact Polly Watt-Geier, MSW, Health Facility Surveyor, Residential Community Care Program, at (208) 334-6626.

Sincerely,

Polly Watt-Geier

POLLY WATT-GEIER, MSW
Team Leader
Health Facility Surveyor
Residential Community Care Program

PWG/sc

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

October 9, 2007

**CERTIFIED MAIL #: 7003 0500 0003 1967 0728**

Cari Riley, Administrator
Emerson House at River Pointe, LLC
8250 West Marigold
Garden City, ID 83714

Dear Ms. Riley:

Based on the complaint investigation survey conducted by our staff at Emerson House at River Pointe, LLC on **September 24, 2007,** we have determined that the facility failed to protect residents from inadequate care. Based on record review and interview it was determined the facility failed to protect 100 percent of the residents' rights by denying the access of an advocacy and protection ageny.

This core issue deficiency substantially limits the capacity of Emerson House at River Pointe, LLC to furnish services of an adequate level or quality to ensure that residents' health and safety are safe-guarded. The deficiency is described on the enclosed Statement of Deficiencies.

You have an opportunity to make corrections and thus avoid a potential enforcement action. Correction of this deficiency must be achieved by **November 9, 2007. We urge you to begin correction immediately.**

After you have studied the enclosed Statement of Deficiencies, please write a Plan of Correction by answering **each** of the following questions for **each** deficient practice:

- What corrective action(s) will be accomplished for those specific residents/personnel/areas found to have been affected by the deficient practice?
- How will you identify other residents/personnel/areas that may be affected by the same deficient practice and what corrective action(s) will be taken?
- What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?
- How will the corrective action(s) be monitored and how often will monitoring occur to ensure that the deficient practice will not recur (i.e., what quality assurance program will be put into place)?
- What date will the corrective action(s) be completed by?

Return the **signed** and **dated** Plan of Correction to us by **October 22, 2007,** and keep a copy for your records. Your license depends upon the corrections made and the evaluation of the Plan of Correction you develop.

In accordance with Informational Letter #2002-16 INFORMAL DISPUTE RESOLUTION (IDR) PROCESS, you have available the opportunity to question cited deficiencies through an informal dispute resolution process. If you disagree with the survey report findings, you may make a written request to the Chief of the Bureau of Facility Standards for a Level 1 IDR meeting. The request for the meeting must be made within ten (10) business days of receipt of the statement of deficiencies (**October 22, 2007**). The specific deficiencies for which the facility asks reconsideration must be included in the written request, as well as the reason for the request for reconsideration. The facility's request must include sufficient information for the Bureau of Facility Standards to determine the basis for the provider's appeal. If your request for informal dispute resolution is received after **October 22, 2007,** your request will not be granted.

Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference. The completed punch list form and accompanying proof of resolution (e.g., receipts, pictures, policy updates, etc.) are to be submitted to this office by **October 24, 2007**.

If, at the follow-up survey, it is found that the facility is not in compliance with the rules and standards for residential care or assisted living facilities, the Department will have no alternative but to initiate an enforcement action against the license held by Emerson House at River Pointe, LLC.

Should you have any questions, or if we may be of assistance, please call our office at (208) 334-6626.

Sincerely,

Patty Ward-Acier for

JAMIE SIMPSON
Supervisor
Residential Community Care Program

JS/sc

Enclosure

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 13R725 | A. BUILDING _____ B. WING _____ | C 09/24/2007 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EMERSON HOUSE AT RIVER POINTE LLC | 8250 W MARIGOLD BOISE, ID 83714 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| R 000 | Initial Comments<br><br>The following deficiency was cited during the complaint investigation conducted at your residential care/assisted living facility. The surveyors conducting your complaint investigation were:<br><br>Polly Watt-Geier, MSW<br>Team Coordinator<br>Health Facility Surveyor<br><br>Rachel Corey, RN<br>Health Facility Surveyor<br><br>Debbie Sholley, LSW<br>Health Facility Surveyor | R 000 | | |
| R 008 | 16.03.22.520 Protect Residents from Inadequate Care.<br><br>The administrator must assure that policies and procedures are implemented to assure that all residents are free from inadequate care.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview it was determined the facility failed to protect 100% of the residents' rights by denying the access of an advocacy and protection agency. The findings include:<br><br>1. Review of the facility's resident's rights on 9/26/07, revealed the facility would guarantee the rights of the residents to include: "Access by advocates and representatives: a care facility/home shall permit advocates and representatives of community legal services program, who purpose include rendering assistance without charge to residents to have | R 008 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| R 008 | Continued From page 1<br>access to the facility/home at reasonable times in order to...observe all common areas of the facility/home." Additionally, the resident rights documented Adult Protection as an advocacy group.<br><br>On 8/17/07 at 9:28 a.m., the Ombudsman stated adult protection services had received a complaint that the facility's internal temperature was excessively high and there was a concern for residents' safety. After receiving the call, adult protection went to the facility on the morning of 8/17/07, and were denied access to review the situation and ensure resident safety.<br><br>On 8/17/07 at 9:35 a.m., an Adult Protection Caseworker stated they had gone to the facility on the morning of 8/17/07. When they arrived at the facility they had identified themselves, but staff refused to allow them access to the facility.<br><br>On 9/4/07 at 3:28 p.m., the administrator confirmed Adult Protection had been denied access when they arrived at the facility. She stated the staff member had been from a temporary agency and had not been aware of the residents rights to allow adult protection access into the facility.<br><br>The facility did not allow Adult Protection access to the facility, when there was a concern for resident safety. This failure resulted in inadequate care. | R 008 | | |

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October 9, 2007

Cari Riley, Administrator
Emerson House at River Pointe, LLC
8250 West Marigold
Garden City, ID 83714

Dear Ms. Riley:

On September 24, 2007, a complaint investigation survey was conducted at Emerson House at River Pointe, LLC. The survey was conducted by Rachel Corey, RN, Polly Watt-Geier, MSW, and Debra Sholley, LSW. This report outlines the findings of our investigation.

**Complaint # ID00003208**

Allegation 1: The facility denied the residents right to access adult protection services when they visited the facility.

Conclusion #1: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.520 for inadequate care due to failure to protect residents' right to access advocacy and protective services. The facility was required to submit a plan of correction.

If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

Polly Watt-Geier, MSW

POLLY WATT-GEIER, MSW
Team Leader
Health Facility Surveyor
Residential Community Care Program

PWG/sc

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Community Care Program

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October 9, 2007

Cari Riley, Administrator
Emerson House at River Pointe, LLC
8250 West Marigold
Garden City, ID 83714

Dear Ms. Riley:

On September 24, 2007, a complaint investigation survey was conducted at Emerson House at River Pointe, LLC. The survey was conducted by Rachel Corey, RN, Polly Watt-Geier, MSW and Debra Sholley, LSW. This report outlines the findings of our investigation.

**Complaint # ID00003156**

Allegation #1: The facility did not act appropriately to protect the residents from becoming overheated when there was no air conditioning on the east unit on August 1, 2007 through August 5, 2007, a total of five days. Additionally, The air conditioning units on the east and west units were down for approximately 2 weeks in July.

Findings: Based on observation, interview and record review it was determined the facility did protect the residents during the time the air condition units were down by bringing in equipment to reduce the temperature and also offered fluids continually to the residents while the the air conditioning unit were being fixed.

On August 8, 2007 at 2:48 p.m., the facility's east wing's thermostat was observed to read at 79.5 degrees.

On August 8, 2007 at 2:51 p.m., a surveyors thermometer was observed to read at 81.1 degrees on the east wings large living room next to the residents rooms.

On August 14, 2007 at 3:09 p.m., the temperature outside of the facility was observed and recorded at 95 degrees. On August 14, 2007 at 3:14 p.m., the east wing's temperature was recorded at 76.4 degrees and the thermostat read as 76 degrees. The west wing's temperature was recorded as 74.3 degrees and the thermostat read as 76 degrees

The facility's air conditioning repair service receipts dated July 13, 2007 through July 20, 2007 and August 3, 2007, documented the air conditioning units were inspected and needed repaired.

On August 8, 2007 at 2:06 p.m., the administrator confirmed the air conditioning unit had gone down on both the east and west sides of the building from July 13, 2007 to July 20, 2007. During that time she had worked with the air conditioning company to have the unit repaired. She also had 2 swamp coolers brought in, purchased fans to be placed throughout the building and new blinds were purchased to block some of the sunlight from entering the building. On July 20, 2007, she stated the air conditioning company had repaired the unit and had said the air conditioning unit had been repaired. On the evening of August 2, 2007, the air conditioning unit on the east unit went out and it did not come to the attention of staff until the next day August 3, 2007. The administrator stated the maintenance worker had power washed the units and the coils had been damaged. The administrator was working on receiving bids to replace the coils and at the same time added 2 portable air coolers and fans to help reduce the heat from mid-day until evening.

On August 14, 2007 at 3:08 p.m., the administrator stated she had four companies inspect the air conditioning unit on the east wing, but all four companies gave four different reasons why the air conditioning unit was not working at full capacity. She stated she had called the manufacturer of the unit to have them inspect the unit to determine what had caused the unit to stop working at full capacity.

Three caregivers were interviewed between August 10, 2007 and August 13, 2007 and confirmed the air conditioning units had been down in July and August of 2007. They also stated the facility worked with the air conditioning repair companies throughout the time the air conditioning unit was down. Additionally, they stated the facility had purchased and used swamp coolers and fans during that time; which alleviated some of the heat. They also stated the residents were offered ice water and cold foods throughout this time.

Eight family members of residents residing in the facility were interviewed between August 17, 2007 and September 8, 2007. They stated the facility had been warm during the time the air conditioning was down, but the facility acted appropriately by purchasing several swamp coolers and fans to alleviate some of the heat. The family members also stated the residents did not have any negative outcomes and none had complained of being hot or uncomfortable. Additionally, family members stated residents were offered plenty of fluids and had not had adverse outcomes due to the air conditioning unit not working effectively.

On September 4, 2007 at 3:38 p.m., the administrator stated the manufacture had found the reason behind the air conditioning unit not working and the unit had been repaired and was fully functional.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation.

Allegation #2: The facility's air conditioning was down and an identified resident was taken to the hospital on August 4, 2007 via ambulance and was admitted with dehydration, heat exhaustion and a UTI.

Findings: Based on record review and interview it could not be determined the resident had been admitted to the hospital due to dehydration or heat exhaustion.

Review of a history and physical dated January 5, 2007 revealed the resident had a history of recurrent urinary tract infections.

The hospital's emergency department report dated August 4, 2007, documented "He also has normal electrolytes so I do not think he is significantly dehydrated." Additionally, the report documented the resident was admitted to the hospital "for treatment of urinary tract infection and evaluation for his mental status condition."

On August 8, 2007 at 2:28 p.m., the administrator stated the residents were offered cool water every hour during the time the air conditioning units were down. She also stated staff were encouraged to limit the residents coffee intake do decrease possible dehydration as well during the time the units were down.

Between August 10, 2007 and August 13, 2007, three caregivers were interviewed and stated the facility had purchased and used swamp coolers and fans during the time the air conditioning units were down; which alleviated some of the heat. Additionally, they stated the residents were offered ice water and cold foods throughout this time and none were aware of a resident who had become dehydrated.

Between August 17, 2007 and September 8, 2007, eight family members of residents residing in the facility were interviewed. They stated the facility had been warm during the time the air conditioning was down, but the facility acted appropriately by obtaining several swamp coolers and fans to alleviate some of the heat. The family members also stated the residents did not have any negative outcomes and none had complained of being hot or uncomfortable. Additionally, family members stated residents were offered plenty of fluids and had not had adverse outcomes due to the air condition unit not working effectively.

Conclusion: Unsubstantiated. Although the allegation may have occurred, it could not be determined the resident had been admitted to the hospital due to the air conditioning unit being down, resulting in dehydration of the identified resident during the complaint investigation.

Allegation #3: The facility did not follow physician's orders when they continued to assist an identified resident with a medication that had been discontinued by the physician.

Findings: A physician's order dated August 1, 2007 documented the following: "Discontinue Aricept"

Review of the August 2007 Medication Assistance Record (MAR), revealed Aricept 5 mg was signed as given to the resident from August 1, 2007 to August 4, 2007, a total of 4 doses.

On August 14, 2007 at 2:30 p.m., the administrator stated the medication had been removed from the medi-set, but the MAR had not been corrected and staff had signed the medication as given.

Conclusion: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.350.02 for the facility nurse not verifying or ensuring medications for the identified resident were current with the physician's order. The facility was also issued a deficiency at IDAPA 16.03.22.711.08.b for not making corrections to the identified resident's MAR when a medication was discontinued by the physician. The facility was required to submit evidence of resolution within 30 days.

If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

Polly Watt-Geier, MSW

POLLY WATT-GEIER, MSW
Team Leader
Health Facility Surveyor
Residential Community Care Program

PWG/sc

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Community Care Program
Polly Watt-Geier, MSW, Health Facility Surveyor

IDAHO DEPARTMENT OF HEALTH & WELFARE

**BUREAU OF FACILITY STANDARDS**
**P.O. Box 83720**
**Boise, ID 83720-0036**
**(208) 334-6626 fax: (208) 364-1888**

# ASSISTED LIVING
## Non-Core Issues
## Punch List

| Facility Name | Physical Address | Phone Number |
|---|---|---|
| Emerson House at River Pointe | 8250 W. Marigold St. | (208) 377-3177 |
| **Administrator** | **City** | **ZIP Code** |
| Cari Riley | Garden City | 83714 |
| **Survey Team Leader** | **Survey Type** | **Survey Date** |
| Polly Watt-Geier | Complaint Investigation | 9/24/07 |

**NON-CORE ISSUES**

| ITEM # | RULE # 16.03.22 | DESCRIPTION | DATE RESOLVED | BFS USE |
|---|---|---|---|---|
| 1 | 350.02 | The facility nurse did not verify or ensure medications for Resident #1 were consistent with the physician or authorized provider's order. | 9/21/07 | 11/8/07 Polly |
| 2 | 711.08.b | The facility did not make corrections to Resident #1's Medication Assistance Record (MAR) when a medication was discontinued by the physician or authorized provider. | 9/21/07 | 11/8/07 Polly |

RECEIVED
OCT 22 2007
FACILITY STANDARDS

| Response Required Date | Signature of Facility Representative | Date Signed |
|---|---|---|
| 10/24/07 | [signature] | 10/19/07 |